

Name _____

The information requested below will enable us to treat you safely. If you have any questions about the information requested, please ask your health care professional (HCP). All information provided below will be kept confidential. Your written permission is required to release any information.

PLEASE CHECK ANY OF THE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED:

<p>[Cardiovascular]</p> <p><input type="checkbox"/> Cardiac Pacemaker</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> Elevated Cholesterol</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Angina/Chest Pain</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Other Heart Problems</p> <p>_____</p>	<p>[Respiratory]</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Bronchitis/Emphysema</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Other Respiratory Problems</p> <p>_____</p> <p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>[Other]</p> <p><input type="checkbox"/> Anxiety/Depression</p> <p><input type="checkbox"/> Cancer (Type) _____</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Connective Tissue Disorders</p> <p><input type="checkbox"/> Thyroid Disorder</p> <p><input type="checkbox"/> Blood Disorder</p> <p><input type="checkbox"/> Communicable Diseases (MRSA, TB, HIV, Herpes, Hepatitis)</p> <p><input type="checkbox"/> Allergies (what?) _____</p> <p><input type="checkbox"/> Steroid treatment <input type="checkbox"/> Injections _____</p> <p><input type="checkbox"/> Internal pins, plates, or joint replacements? _____</p>
<p>[Head / Neck]</p> <p><input type="checkbox"/> Headaches (how often?) _____</p> <p><input type="checkbox"/> Migraines (how often?) _____</p> <p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Vertigo</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Vision Problems/ Loss</p> <p><input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> Blurred Vision</p> <p><input type="checkbox"/> Ear Problems/Loss</p> <p><input type="checkbox"/> Difficulty Speaking</p> <p><input type="checkbox"/> Difficulty Swallowing</p>	<p>[Neurological]</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Traumatic Brain Injury</p> <p><input type="checkbox"/> Concussion/Head Trauma</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Parkinson's Disease</p> <p><input type="checkbox"/> Epilepsy/Seizures</p> <p><input type="checkbox"/> Loss of sensation (where): _____</p> <p><input type="checkbox"/> Other Neurological Disorders _____</p>	<p>[Women]</p> <p><input type="checkbox"/> Pregnant, due date: _____</p> <p><input type="checkbox"/> Incontinence <input type="checkbox"/> Prolapse</p> <p><input type="checkbox"/> Menstrual Problems</p>

Please List All Medications (Prescription/Non-Prescription):

What made you decide to come to our clinic? (Check any that apply to you)		
<p><input type="checkbox"/> Sent by Doctor</p> <p><input type="checkbox"/> Been to clinic before</p> <p><input type="checkbox"/> Sent by WCB/MPI</p> <p><input type="checkbox"/> Referred by friend/relative (name)</p> <p>_____</p>	<p><input type="checkbox"/> Workplace</p> <p><input type="checkbox"/> Last minute physio/massage</p> <p><input type="checkbox"/> Website</p> <p><input type="checkbox"/> Facebook/Instagram</p> <p><input type="checkbox"/> Google Listing/Review</p>	<p><input type="checkbox"/> Radio/TV Advertisement</p> <p><input type="checkbox"/> Location/Signage</p> <p><input type="checkbox"/> Word of Mouth</p> <p><input type="checkbox"/> Other: _____</p>